§157.131 Designated trauma facility and emergency medical services account

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Extraordinary emergency--An event or situation which may disrupt the services of an EMS/trauma system.

(2) Rural county--A county with a population of less than 50,000 based on the latest official federal census population figures.

(3) Urban county--A county with a population of 50,000 or more based on the latest official federal census population figures.

(4) Emergency transfer--is defined as any medically-ordered, immediate transfer of an emergent or unstable patient from a health care facility to a health care facility which has the capability of providing a higher level of care or of providing a specialized type of care not available at the transferring facility.

(5) Trauma care –is care provided to patients who underwent treatment specified in at least one of the following ICD-9 codes: between 800.00 and 959.9, including 940.0-949.0 (burns), excluding 905.0-909.0 (late effects of injuries), 910.0-924.0 (blisters, contusions, abrasions, and insect bites), 930.0 – 939.0 (foreign bodies), and who underwent an operative intervention as defined in sub-section (a) (9) of this section or was admitted as an inpatient for >23hours or who died after receiving any emergency department evaluation or treatment or was dead on arrival or who transferred into or out of the hospital.

(6) Uncompensated trauma care-- is defined as the sum of "charity care" and "bad debt" resulting from trauma care as defined in (a)(5) of this section after due diligence to collect. Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (to include but not limited to Medicaid, Medicare, Children's Health Insurance Program (CHIP), etc.) is not uncompensated trauma care.

(7) Charity care-- is the unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services on an inpatient or emergency department basis to a person classified by the hospital as "financially indigent" or "medically indigent".

(A) Financially indigent-- is defined as an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system.

(B) Medically indigent-- is defined as a person whose medical or hospital bills after payment by third-party payors (to include but not limited to Medicaid, Medicare, CHIP, etc.) exceed a specified percentage of the patient's annual gross income, determined in

accordance with the hospital's eligibility system, and the person is financially unable to pay the remaining bill.

(8) Bad debt-- is the uncollectible trauma care charges, as defined in (a) (5) of this section, that result from the extension of credit based upon the hospital's bad debt policy. A hospital's bad debt policy should be in accordance with generally accepted accounting principles.

(9) Operative intervention –Any surgical procedure resulting from a patient being taken directly from the emergency department to an operating suite regardless of whether the patient was admitted to the hospital or discharged from the hospital.

(10) Active pursuit of TDH-trauma designation-- is as follows:

(A) By December 31, 2003 an undesignated licensed hospital must submit;

(i) a complete application with the state trauma designation program or appropriate agency for trauma verification;

(ii) evidence of participation in Trauma Services Area (TSA) Regional Advisory Council (RAC) initiatives;

(iii) evidence of a hospital trauma performance improvement committee.

(B) Submission of data to the TDH-EMS/Trauma Registry.

(b) Reserve. On September 1 of each year, there shall be a reserve of $500,000 in the designated trauma facility and emergency medical services account (account) for extraordinary emergencies. During the fiscal year, distributions may be made from the reserve by the commissioner of health based on requests which demonstrate need and impact on the EMS and trauma care system (system).

(1) Proposals not immediately recommended for funding will be reconsidered at the end of each fiscal year, if funding is available, and a need is still present.

(c) Allocations. The EMS allocation shall be not more than 2%, the TSA allocation shall be not more than 1%, and the hospital allocation shall be at least 96% of the funds appropriated from the account after any amount necessary to maintain the extraordinary emergency reserve of $500,000 has been deducted.

(1) Each year, the bureau of emergency management (department) shall determine:

(A) Eligible recipients for the EMS allocation, TSA allocation, and hospital allocation;

(B) The amount of the TSA allocation, the EMS allocation, and the hospital allocation.

(C) Each county's share of the EMS allocation;

(D) Each RAC's share of the TSA allocation; and

(E) Each facility's share of the hospital allocation.

(2) The department shall contract with each eligible RAC to distribute the county shares of the EMS allocation to eligible EMS providers based within counties which are aligned within the relevant RAC. Prior to distribution of the county shares to eligible providers, the RAC shall submit a distribution proposal, approved by the RAC's voting membership, to the department for approval.

(A) The county portion of the EMS allocation shall be distributed directly to eligible recipients without any reduction in the total amount allocated by the department and shall be used as an addition to current county EMS funding of eligible recipients, not as a replacement.

(B) The department shall evaluate each RAC's distribution plan based on the following:

(i) fair distribution process to all eligible providers, taking into account all eligible providers participating in contiguous TSAs;

(ii) needs of the EMS providers;

(iii) evidence of consensus opinion for eligible entities.

(C) A RAC opting to use a distribution plan from the previous fiscal year shall submit, to the department, a letter or email of intent to do so.

(D) Eligible EMS providers may opt to pool funds or contribute funds for a specified RAC purpose.

(3) The department shall contract with eligible RACs to distribute the TSA allocation. Prior to distribution of the TSA allocation, the RAC shall submit a budget proposal to the department for approval. The department shall evaluate each RAC's budget according to the following:

(A) budget reflects all funds received by the RAC, including funds not expended in the previous fiscal year;

(B) budget contains no ineligible expenses;

(C) appropriate mechanism is used by RAC for budgetary planning; and

(D) program areas receiving funding are identified by budget categories.

(4) The department shall distribute funds directly to facilities eligible to receive funds from the hospital allocation to subsidize a portion of uncompensated trauma care provided or to fund innovative projects to enhance the delivery of patient care in the overall EMS/Trauma System.

(A) Funds distributed from the hospital allocations shall be made based on, but not limited to:

(i) the percentage of the hospital's uncompensated trauma care cost in relation to total uncompensated trauma care cost reported by qualified hospitals that year; and

(ii) availability of funds.

(d) Eligibility requirements. To be eligible for funding from the account, all potential recipients (EMS Providers, RACs, Registered First Responder Organizations and hospitals) must maintain active involvement in regional system development. Potential recipients also must meet requirements for reports of expenditures from the previous year and planning for use of the funding in the upcoming year.

(1) To be eligible to receive extraordinary emergency funding, an entity must:

(A) Be a licensed EMS provider, a licensed hospital, or a registered first responder organization;

(B) Submit a written request, containing the entity name, contact information, amount of funding requested, and a description of the extraordinary emergency to the Chief of the department; and

(C) Return a signed extraordinary emergency information checklist to the department.

(2) To be eligible for funding from the EMS allocation, an EMS provider must:

(A) Maintain provider licensure as described in §157.11 of this title and provide emergency medical services and/or emergency transfers;

(B) Demonstrate utilization of the RAC regional protocols regarding patient destination and transport in all TSAs in which they operate (verified by each RAC);

(C) Demonstrate active participation in the regional system performance improvement (PI) program in all TSAs in which they operate (verified by each RAC);

(D) An EMS provider licensed in or contracted to provide emergency medical services in a county that is contiguous with a neighboring TSA may participate on either RAC:

(i) participation on both RACs is encouraged;

(ii) RAC participation shall follow actual patient referral patterns;

(iii) an EMS provider contracted to provide emergency medical services within a county of any one TSA with a provider license that reflects another county not in or contiguous with that TSA must be an active member of the RAC for the TSA of their contracted service area and meet that RAC's definition of participation and requirements listed in sub-section (d)(2)(E)(i)-(vi) of this section; and

(iv) it is the responsibility of the licensed and/or contracted EMS provider to contact each RAC in which it operates to ensure knowledge of the provider's presence and potential eligibility for funding from the EMS allocation in the respective TSA.

(E) Providers serving any county beyond county of licensure must provide evidence of contract or letter of agreement with each additional county government or taxing authority in which service is provided:

(i) inter-facility transfer letters of agreement and/or contracts, as well as mutual aid letters of agreement and/or contracts, do not meet this requirement;

(ii) contracts or letters of agreement must be dated and submitted to the department on or before August 31 of the respective year, and be effective more than six months of the upcoming year;

(iii) effective dates of the contract or letter of agreement should be provided;

(iv) EMS providers with contracts or letters of agreement on file with the department which include contract service dates that meet the required time period need not resubmit;

(v) EMS providers are responsible for assuring that all necessary portions of their contracts and letters of agreement have been received by the department; and

(vi) air ambulance providers must meet the same requirements as ground transport EMS providers to be eligible to receive funds from a specific county other than the county of licensure.

(F) An EMS provider, licensed in a particular county and having a contract (with a county government or taxing authority) for a service area which is a geopolitical subdivision (examples listed below) and crosses multiple county lines, will be considered eligible for the 911 EMS Allocation for all counties served which compose the geopolitical subdivision. A contract with every county that composes the geopolitical subdivision is not necessary; and

(G) Eligibility of EMS providers licensed in a geopolitical subdivision other than those listed below in sub-section (d)(2)(G)(i) – (vi) of this sub-section will be evaluated on a case-by-case basis.

(i) municipalities;

(ii) school districts;

(iii) emergency service districts (ESDs);

(iv) hospital districts;

(v) utility districts; or

(vi) prison districts;

(3) To be eligible for funding from the TSA allocation, a RAC must:

(A) Be officially recognized by the department as described in §157.123 of this title;

(B) Be incorporated as a 501 (c) (3) with the Internal Revenue Service;

(C) Submit documentation of ongoing system development activity and future planning;

(D) Have demonstrated that a regional system PI process is ongoing by submitting to the department the following:

(i) lists of committee meeting dates and attendance rosters for the current calendar year; or

(ii) committee membership rosters which included each member's organization or constituency; or

(iii) lists of issues being reviewed in the system performance improvement meetings.

(E) Submit all required EMS allocation eligibility items addressed in sub-section (d) (2) (B) - (C) of this section.

(4) To be eligible to distribute the EMS and TSA allocations, a RAC must be incorporated as an entity that is exempt from federal income tax under the Internal Revenue

Code of 1986, §501(a), and its subsequent amendments, by being listed as an exempt organization under §501(c)(3) of the code.

(5) To be eligible for funding from the hospital allocation, a facility must be a TDH-designated trauma facility or an undesignated facility in active pursuit of TDH-trauma designation or a Department of Defense hospital that is TDH-trauma designated or in active pursuit of TDH-trauma designation.

(A) To receive funding from the hospital allocation, an application must be submitted within the time frame specified by the department and include the following:

(i) name of facility;

(ii) location of facility including mailing address, city and county;

(iii) Texas Provider Identifier (TPI number) or accepted federal identification number; and

(iv) total uncompensated trauma care as defined above. The reporting period of a facility's uncompensated trauma care shall apply to charges incurred during the preceding calendar year as this is the most recent, complete data available.

(B) The application must be signed by the chief financial officer, chief executive officer and the chairman of the facility's board of directors;

(C) The form must be notarized, and;

(D) Additional information may be requested at the department's discretion.

(E) A TDH-designated trauma facility in receipt of funding from the hospital allocation that fails to maintain designation through December 31, 2005 must return an amount as follows to the account by no later than January 31, 2006:

(i) 1 to 60 days lapsed designation: 0% of the facility's hospital allocation for FY04 and FY05.

(ii) 60 to 180 days lapsed designation: 25% of the facility's hospital allocation for FY04 and FY05 plus a penalty of 10%.

(iii) greater than 180 days lapsed designation: 100% of the facility's hospital allocation for FY04 and FY05 plus a penalty of 10%.

(iv) the department may grant an exception to sub-section (d) (5) (E) of this section if it finds that compliance with this section would not be in the best interests of the persons served in the affected local system.

(F) A facility in active pursuit of designation but has not achieved TDH-trauma designation by December 31, 2005, must return to the account by no later than January 31, 2006 all funds received from the hospital allocation in FY04 and FY05 plus a penalty of 10%.

(e) Calculation of county shares of the EMS allocation, the RAC shares of the TSA allocation, and the hospital allocation.

(1) EMS allocation.

(A) Counties will be classified as urban or rural based on the latest official federal census population figures.

(B) The EMS allocation will be derived by adjusting the weight of the statutory criteria in such a fashion that, in so far as possible, 40% of the funds are allocated to urban counties and 60% are allocated to rural counties.

(C) An individual county's share of the EMS allocation shall be based on its geographic size, population, and number of emergency health care runs multiplied by adjustment factors so the distribution approximates the required percentages to urban and rural counties.

(D) The formula shall be: (((the county's population times an adjustment factor) plus (the county's geographic size times an adjustment factor) plus (the county's total emergency health care runs times an adjustment factor) divided by 3)) times (the total EMS allocation). The adjustment factors will be manipulated so that the distribution approximates the required percentages to urban and rural counties. Total emergency health care runs shall be the number of emergency runs electronically transmitted to the department in a given calendar year by EMS providers.

(2) TSA allocation.

(A) A RAC's share of the TSA allocation shall be based on its relative geographic size, population, and trauma care provided as compared to all other TSAs.

(B) The formula shall be: (((the TSA's percentage of the state's total population) plus (the TSA's percentage of the state's total geographic size) plus (the TSA's percentage of the state's total trauma care) divided by 3)) times (the total TSA allocation). Total trauma care shall be the number of trauma patient records electronically transmitted to the department in a given calendar year by EMS providers and hospitals.

(3) Hospital allocation.

(A) Designated Level I, II, III and IV trauma facilities and those facilities in active pursuit of designation shall apply to the department for funds from the hospital allocation

plus any unexpended portion of the EMS and TSA allocations by demonstrating their uncompensated trauma care costs. Each facility shall receive:

(i) an equal amount, with an upper limit of $50,000, from up to 15 percent of the hospital allocation; and

(ii) an amount for uncompensated trauma care as determined in sub-sections (3)(B)-(C) of this section, less the amount received in sub-section (3)(A)(i) of this section.

(B) Any funds not allocated in sub-section (3)(A)(i) of this section shall be included in the distribution formula in sub-section (3)(D) of this section.

(C) If the total cost of uncompensated trauma care exceeds the amount appropriated from the account, minus the amount referred to in sub-section (3)(A)(i) of this section, the department shall allocate funds based on a facility's percentage of uncompensated trauma care costs in relation to the total uncompensated trauma care cost reported by qualified hospitals that year.

(D) In the first year of distribution, the formula for Level I, II, III and IV trauma facilities and those facilities in active pursuit of designation shall be: (((the facility's reported charges for uncompensated trauma care) times (the facility's Medicaid cost to charge ratio as reported from tentative or settled cost reports for the period ending in the prior calendar year) divided by (the total reported cost of uncompensated trauma care by qualified hospitals that year.)) times ((total money available for facilities minus the amount referred to in sub-section (e)(3)(A)(i)) of this section.

(E) In subsequent years of distribution, the formula for Level I, II, III and IV trauma facilities and those facilities in active pursuit of designation shall be: ((((the facility's reported charges for uncompensated trauma care) minus (any collections received by the hospitals for any portion of their uncompensated care previously reported for the purposes of this section) times (the facility's Medicaid cost to charge ratio as reported from tentative or settled cost reports for the period ending in the prior calendar year) divided by (the total reported cost of uncompensated trauma care by qualified hospitals that year.)) times (total money available for facilities minus the amount distributed in sub-section (e)(3)(A)(i))) of this section.

(F) Hospitals should have an agreed upon physician incentive plan that supports facilities' participation in the trauma system.

(f) Loss of funding eligibility. If the department finds that an EMS provider, RAC, or hospital has violated the Health and Safety Code, §780.004 or fails to comply with this section, the department may withhold account monies for a period of one to three years depending upon the seriousness of the infraction.